SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Filing at a Glance

Company: Humana Insurance Company

Product Name: HIC Group Critical Illness - HIC GP CI 10/11	SERFF Tr Num: ICCI-127881884	State: Arkansas
TOI: H07G Group Health - Specified Disease - Limited Benefit	SERFF Status: Closed-Approved	State Tr Num: 50504
Sub-TOI: H07G.001 Critical Illness	Co Tr Num: HIC GP CI 10/11	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Donna Lambert
	Author: Brenda Dawson	Disposition Date: 12/20/2011
	Date Submitted: 12/16/2011	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date: 01/20/2012

State Filing Description:

General Information

Project Name: HIC Group Critical Illness	Status of Filing in Domicile:
Project Number: HIC GP CI 10/11	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 12/20/2011	
State Status Changed: 12/20/2011	Deemer Date:
Created By: Brenda Dawson	Submitted By: Brenda Dawson

Corresponding Filing Tracking Number:

Filing Description:

We are hereby submitting the forms attached to the Form Schedule tab for filing in your state. These forms are new and are not intended to replace any forms previously approved in your state.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Humana Insurance Company, a Wisconsin domiciled company. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc.

Group Critical Illness Policy HIC-GP-CI-POL 10/11 provides for critical illness benefits.

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Form HIC-CI-GP-CERT-AR 06-11 is the certificate of insurance evidencing coverage under the group policy.

Waiver of Premium Due to Sanctioned Strike Benefit Rider HIC-GP-SPW 11/09 will also be used with this policy form. This Rider was previously approved by your Department on March 1, 2011, under SERFF Tracking # ICCI-127018289.

Form HIC-CI-ERAPP 6-11 is the employer application. Form HIC-CI-EE-EF 6/11 is the employee enrollment form. Form HIC-CI-EOI-APP 10/11 is the evidence of insurability application.

This is a true group employer form.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions. These forms were prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style and/or page spacing changes. However, there will not be any changes to the actual text of the contract or to the general print size.

Company and Contact

Filing Contact Information

Brenda Dawson, Authorized Representative
3925 East State Street, Suite 200
Rockford, IL 61108

Brendadawson@inscompliance.com
815-316-6714 [Phone]
815-986-2355 [FAX]

Filing Company Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)

Humana Insurance Company
P.O Box 740036
500 West Main Street

Louisville, KY 40201-7436
(502) 580-2712 ext. [Phone]

CoCode: 73288
Group Code: 119
Group Name: Humana Insurance Company
FEIN Number: 39-1263473

State of Domicile: Wisconsin
Company Type: L&H
State ID Number:

Filing Fees

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Fee Required?	Yes
Fee Amount:	$250.00
Retaliatory?	No
Fee Explanation:	$50 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	$250.00	12/16/2011	54598217

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	12/20/2011	12/20/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Donna Lambert	12/19/2011	12/19/2011	Brenda Dawson	12/20/2011	12/20/2011

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Disposition

Disposition Date: 12/20/2011
Implementation Date: 01/20/2012
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	No
Supporting Document	Application	Approved	No
Supporting Document	Humana Insurance Company	Approved	No
Form	Group Critical Illness Policy	Approved	No
Form	Group Critical Illness Certificate	Approved	No
Form *(revised)*	Employer Application	Approved	No
Form	Employer Application	Replaced	No
Form *(revised)*	Employee Enrollment form	Approved	No
Form	Employee Enrollment form	Replaced	No
Form *(revised)*	Evidence of Insurability form	Approved	No
Form	Evidence of Insurability form	Replaced	No

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/19/2011
Submitted Date	12/19/2011
Respond By Date	01/19/2012

Dear Brenda Dawson,

This will acknowledge receipt of the captioned filing.

Please attach a Flesch certification.

Objection 1

- Employer Application, HIC-CI-ERAPP 6-11 (Form)

Comment: Please revise the fraud warning to include reference to "fines and confinement in pison" as required by 23-66-503.

Objection 2

- Employee Enrollment form, HIC-CI-EE-EF 6/11 (Form)

Comment: Please add the fraud warning required by 23-66-503: “Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.”

Objection 3

- Evidence of Insurability form, HIC-CI-EOI-APP 10/11 (Form)

Comment: Please add the fraud warning required by 23-66-503: “Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.”

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.
Sincerely,

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Donna Lambert

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/20/2011
Submitted Date	12/20/2011

Dear Donna Lambert,

Comments:
Thank you for your letter.

Response 1

Comments: This application was revised to include the Arkansas fraud warning.

Related Objection 1

Applies To:

- Employer Application, HIC-CI-ERAPP 6-11 (Form)

Comment:

Please revise the fraud warning to include reference to "fines and confinement in pison" as required by 23-66-503.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Employer Application	HIC-CI-ERAPP-AR 6-11		Application/Enrollment Form	Initial		0.000	AR HIC-CI-ERAPP-AR 06-11 _Employer app_ 12-20-11.pdf

Previous Version

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Employer Application	*HIC-CI-ERAPP 6-11*	*Application/Enrollment Form*	*Initial*	*0.000*	HIC-CI-ERAPP 06-11 _rev 11-11_.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: This form was revised to include the Arkansas fraud warning.

Related Objection 1

Applies To:

- Employee Enrollment form, HIC-CI-EE-EF 6/11 (Form)

Comment:

Please add the fraud warning required by 23-66-503: “Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.”

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Employee Enrollment form	HIC-CI-EE-EF-AR 6/11		Application/Enrollment Form	Initial		0.000	AR HIC-CI-EE-EF 6-11 _enrollment app_ 12-20-11.pdf
Previous Version							
Employee Enrollment	*HIC-CI-*		*Application/Enrollment*	*Initial*		*0.000*	HIC-CI-

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

form	*EE-EF 6/11*	*Form*	EE-EF 6-11 _enrollment app_ 10-11-11 _2_.pdf

No Rate/Rule Schedule items changed.

Response 3

Comments: This form was revised to include the Arkansas fraud warning.

Related Objection 1

Applies To:

- Evidence of Insurability form, HIC-CI-EOI-APP 10/11 (Form)

Comment:

Please add the fraud warning required by 23-66-503: “Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.”

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Employer Application	HIC-CI-ERAPP-AR 6-11		Application/Enrollment Form	Initial		0.000	AR HIC-CI-ERAPP-AR 06-11 _Employer app_ 12-20-11.pdf

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Previous Version					
Employer Application	*HIC-CI-ERAPP 6-11*	*Application/Enrollment Form*	*Initial*	*0.000*	HIC-CI-ERAPP 06-11 _rev 11-11_.pdf
Employee Enrollment form	HIC-CI-EE-EF-AR 6/11	Application/Enrollment Form	Initial	0.000	AR HIC-CI-EE-EF 6-11 _enrollment app_ 12-20-11.pdf
Previous Version					
Employee Enrollment form	*HIC-CI-EE-EF 6/11*	*Application/Enrollment Form*	*Initial*	*0.000*	HIC-CI-EE-EF 6-11 _enrollment app_ 10-11-11 _2_.pdf
Evidence of Insurability form	HIC-CI-EOI-APP-AR 10/11	Application/Enrollment Form	Initial	0.000	AR HIC-CI-EOI-APP-AR 10-11 _Evidence of Insurability _ 12-20-11.pdf
Previous Version					
Evidence of Insurability form	*HIC-CI-EOI-APP 10/11*	*Application/Enrollment Form*	*Initial*	*0.000*	HIC-CI-EOI-APP 10-11 _Evidence of

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Insurability _ 10-11-11.pdf

No Rate/Rule Schedule items changed.

Your review for approval is greatly appreciated. Thank you.

Sincerely,
Brenda Dawson

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Form Schedule

Lead Form Number: HIC-GP-CI-POL 10/11

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 12/20/2011	HIC GP CI 10/11	Policy/Contract/Fraternal Certificate	Group Critical Illness Policy	Initial		0.000	HIC-GP-CI-POL 10-11 _Group Critical Illness Policy_ clean copy.pdf
Approved 12/20/2011	HIC-CI-GP-CERT-AR 06-11	Certificate	Group Critical Illness Certificate	Initial		0.000	AR HIC-CI-GP-CERT-AR 6-11.pdf
Approved 12/20/2011	HIC-CI-ERAPP-AR 6-11	Application/ Enrollment Form	Employer Application	Initial		0.000	AR HIC-CI-ERAPP-AR 06-11 _Employer app_ 12-20-11.pdf
Approved 12/20/2011	HIC-CI-EE-EF-AR 6/11	Application/ Enrollment Form	Employee Enrollment form	Initial		0.000	AR HIC-CI-EE-EF 6-11 _enrollment app_ 12-20-11.pdf
Approved 12/20/2011	HIC-CI-EOI-APP-AR 10/11	Application/ Enrollment Form	Evidence of Insurability form	Initial		0.000	AR HIC-CI-EOI-APP-AR 10-11 _Evidence of Insurability_ 12-20-11.pdf

Humana Insurance Company

1100 Employers Boulevard
Green Bay, Wisconsin 54344
1-800-845-7519

GROUP CRITICAL ILLNESS POLICY

Policyholder: **[ABC Company]**

Policy Number: **[123]**

Policy Date: **[JANUARY 1, 2011]**

Anniversary Date: **[JANUARY 1, of each year]**

MASTER POLICY

This Policy is a legal contract between the Policyholder and Us. To understand the coverage, the Policyholder must read this Policy as a whole.

In this Policy, the words Named Insured refer to those persons who are members of an eligible class as described in the Certificate Schedule and who hold a Certificate of Insurance. Benefit payment is governed by the terms of this Policy. The words Covered Person refer to any person covered under this Policy as described on the Certificate Schedule. The words We, Us, Our or Company refer to Humana Insurance Company. The male pronoun includes the female whenever used.

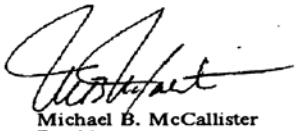
We agree to insure certain individuals and to pay the benefits provided by this Policy in accordance with its provisions.

This Policy is issued in consideration of statements made in the application and the payment of premiums by the Policyholder. A copy of the signed application will be attached and made a part of this Policy.

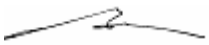
This Policy is effective on the Policy Date. The Policy Date will be the date of issue. The first Policy Year will end on the anniversary date shown above. Each Policy Year after that will end on the same date of each year. All periods will begin and end at 12:01 A.M. Standard Time at the Policyholder's main address.

This Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For Humana Insurance Company:



Michael B. McCallister
President



Gerald L. Ganoni
Vice President

TABLE OF CONTENTS

INCORPORATION PROVISION

The provisions of the attached Certificate and all amendments to this Group Policy after its effective date are incorporated into and made part of this Group Policy.

The terms used in this Policy have the same meaning given to those terms in the Certificate unless otherwise specifically defined in this Policy.

CERTIFICATE

The Certificates, including the Certificate Schedules, amendments, riders and supplements, if any, are a written statement prepared by Us to set forth a summary of:

- benefits to which a Covered Person is entitled;
- to whom the benefits are payable; and
- limitations or requirements that may apply.

ELIGIBILITY AND EFFECTIVE DATE

Policy Effective Date
Coverage under this Policy begins at 12:01 a.m. Standard Time on the Policy Date shown on page 1 of this Policy.

TERMINATION OF INSURANCE

Termination of This Policy
This Policy can be cancelled:

- by the Policyholder; or
- by Us.

If the premium is not paid when it is due or during the grace period, this Policy will terminate at midnight on the last day for which premium was paid. The Policyholder must pay all premiums due for the full period each Certificate is in force.

If We cancel this Policy for reasons other than the Policyholder's failure to remit premium, a written notice will be delivered to the Policyholder at least 60 days prior to the cancellation date.

The Policyholder may cancel this Policy by written notice delivered to Us at least 31 days prior to the cancellation date. This Policy can be cancelled on an earlier date if We both agree. Coverage will end at 12:00 midnight Standard Time on the cancellation date.

PREMIUMS

When and Where to Pay Premiums
The premiums for the coverage must be paid to Us at Our home office or to Our administrator when they are due. The premium due dates are based on the effective dates of the coverage shown on the Certificate Schedules.

Each monthly premium will be calculated on the basis of Our record as to the number of Covered Persons in each coverage classification at the time of calculation, at the premiums then in effect.

Our Right to Change Premiums
We have the right to change the premium We charge. If We plan to make a change, We will send the Policyholder a notice at least 60 days in advance.

However, We may change premium rates at any time for reasons which affect the risk assumed, including the reasons shown below:

- a change occurs in the plan design;
- a division, subsidiary, or affiliated company is added or deleted;
- a substantial change occurs in the participation level of Primary Insureds;
- the number of Primary Insureds changes by 25% or more; or
- a new law or a change in any existing law is enacted which applies to this Policy.

PARTICIPATION REQUIREMENTS

The following participation requirements must be met and maintained for coverage to be effective initially and continue in force The Group Policy may be terminated by Us for the Policyholder's failure to meet participation requirements. The Policyholder agrees that the following participation requirements apply:

For Policies for Which Issue Was Guaranteed

a. For a Policyholder with [100 to 499] or fewer persons in an eligible class, enrollment of at least [25%] of such persons as Named Insureds under this Policy must be met initially and maintained.
b. For a Policyholder with [500 to 999] or more persons in an eligible class, enrollment of at least [20%] of such persons as Named Insureds under this Policy must be met initially and maintained.
c. For a Policyholder with more than [1,000] persons in an eligible class, enrollment of at least [15%] of such persons as Named Insureds under this Policy must be met initially and maintained.

For Policies for Which Issue Was Not Guaranteed

Regardless of the number of persons in an eligible class, enrollment of at least [5] of such persons as Named Insureds under this Policy must be met initially and maintained.

POLICYHOLDER NOT OUR AGENT

The Policyholder will not be considered our agent for any purpose under this Policy.

GENERAL PROVISIONS

Coverage Provided by This Policy.
We insure a Covered Person for a loss according to the provisions of this Policy.

Entire Contract; Changes. This Policy, the Policyholder's Application, and any attached Riders or Amendments make up the entire contract. A copy of the Named Insured's Application is attached. In the absence of fraud, all statements made on any application will be considered representations and not warranties. No written statement made by the Named Insured will be used in any contest unless a copy of the statement is furnished to the Named Insured or his or her personal representative.

No change in this Policy or a Certificate will be valid until approved by an officer of the Company. The change must be signed by an officer of the Company and attached to this Policy. No agent may change this Policy or waive any of its provisions. Any change that modifies, limits or excludes a Named Insured's coverage must contain the Named Insured's signature in order for the change to be binding.

Incontestability. This Policy will not be contested after it has been in force for two year(s) from the Policy Effective Date, except as to nonpayment of premiums.

After two years from the Policy Effective Date, no misstatements made in the Policyholder's Application, except fraudulent misstatements, will be used to contest this Policy.

Physical Examination. We, at Our own expense, have the right and opportunity to examine the person of any individual whose loss is the basis of claim under this Policy when and as often as We may reasonably require during the pendency of the claim.

Legal Actions. No action at law or in equity may be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Noncompliance with Policy Requirements. Any express waiver by Us of any requirements of this Policy will not constitute a continuing waiver of such requirements. Any failure by Us to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Conformity with State Statutes. Any provision of this Policy and any Certificate which, on its Effective Date, is in conflict with the statutes of the state in which this Policy or any Certificate is delivered is hereby amended to conform to the minimum requirements of those statutes.

Clerical Error. Clerical error, whether by the Policyholder or Us, will not void the insurance of any Covered Person if that insurance would otherwise have been in effect or extend the insurance of any Covered Person if that insurance would otherwise have ended or been reduced as provided in this Policy.

Misstatement of Age. If premiums for the Covered Person are based on age and the Covered Person's age has been misstated, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Covered Person is insured are based on age and the Covered Person's age has been misstated, there will be an adjustment of said benefit based on his or her true age. We may require satisfactory proof of age before paying any claim.

Termination of a Covered Person. Upon the termination of coverage of a Covered Person, the premium under this Policy shall be the applicable premium for the remaining Covered Persons.

Refund of Unearned Premium. If a Covered Person dies, any premium paid to Us on behalf of the deceased for a period after the date of such death will be refunded on a pro-rata basis. Notice of death should be sent to Us within 12 months, or as soon as reasonably possible, after a Covered Person has died.

Information to Be Furnished By the Policyholder.
The Policyholder must keep a record of the Named Insureds and the particulars of the insurance on each. The Policyholder must provide Us at regular intervals, on forms acceptable to Us, information relative to persons:

- who are eligible to enroll;
- who are insured by the coverage; and
- whose coverage terminates pursuant to the "Termination Dates" provision.

The Policyholder must also provide Us with any other information about the coverage that may be reasonably required, such as Named Insureds on leave of absence.

We have the right to inspect the Policyholder's records which may have a bearing on the insurance provided by this Policy. We may inspect the records at any time while this Policy is in force and within one year after the termination of this Policy.

HUMANA INSURANCE COMPANY

[1100 Employers Boulevard]
[Green Bay, Wisconsin 54344]

TELEPHONE [1-800-635-4252]

GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE
NON-PARTICIPATING

[POLICYHOLDER LOGO (OPTIONAL)]

CERTIFICATE OF GROUP CRITICAL ILLNESS INSURANCE FOR:

[EXEMPT EMPLOYEES OF XYZABC, INC.]

[OTHER NAMED CLASS]

[OTHER NAMED CLASS]

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INSURING INFORMATION

Humana Insurance Company has issued Group Critical Illness Insurance Policy [##########] ("the Policy") to the Policyholder:

[XYZABC, Inc.]
[1234 Any Street]
[Any City, Any State 99999]

The Policy's Initial Effective date was [January 1, 2008].

Your Date of Certificate is [January 1, 2008].

This is a Certificate issued under the terms of the Policy. It is a summary of the Policy.

Provisions that are in the Policy but not in this Certificate are:

- Termination;
- Premium Provisions; and
- some General Provisions.

If the Policy and this Certificate differ, the Policy will govern. On request, the Policyholder will provide You with the Policy or a copy of it for review.

SCHEDULE

[**CRITICAL ILLNESS BENEFITS**

Insureds:	[Exempt Employees] [Other Named Class] [Other Named Class]
Maximum Issue Amount:	[Exempt Employees][$###,###] [Other Named Class] [$###,###] [Other Named Class] [$###,###]
Face Amount	[$###,###]

_____

Benefit Groups

[Vascular:

Heart Attack	[100%] of Face Amount
Heart Transplant	[100%] of Face Amount
Stroke	[100%] of Face Amount
[Coronary Artery Bypass Surgery	[25%] of Face Amount]]
[Angioplasty	[10% of Face Amount]

[Cancer:

Invasive Cancer or Malignant Melanoma	[100%] of Face Amount
Carcinoma in Situ	[25%] of Face Amount]

[Other Critical Illnesses:

Major Organ Transplant	[100%] of Face Amount
End Stage Renal Failure	[100%] of Face Amount
Loss of Vision, Speech or Hearing	[100%] of Face Amount
Coma	[100%] of Face Amount
Severe Burns	[100%] of Face Amount
Permanent Paralysis due to Accident	[100%] of Face Amount
Occupational HIV Benefit	[100%] of Face Amount
Alzheimer's Dementia	[100%] of Face Amount
Loss of Independent Living	[25%] of Face Amount
Diabetes (Type I or II)	[10%] of Face Amount

_____

[Subject to the Recurrence Benefits,][payment of Benefits within a Benefit Group will not exceed [100%] of the Face Amount.] [Subject to the Recurrence Benefits,][payment of Benefits within the Vascular and Cancer Benefit Groups will not exceed [100%] of the Face Amount and Other Critical Illnesses Benefit Group will not exceed [50%] of the Face Amount.] [Payment of Benefits shall not exceed 300% of the Face Amount.

[Vascular][,][Cancer][and][Other] Critical Illness Benefits reduce by 50% at Age 70]

SCHEDULE

[Recurrence Benefit (limit one per Covered Person)	[25%] of the Benefit previously paid for the recurring Critical Illness]
[Loss of Work Benefit	Maximum [#] Months, Waiver of Premium when the Covered [Employee] is Laid Off, Locked Out or On Strike]
[Waiver of Premium Benefit	Waives Certificate Premiums when Covered [Employee] is Totally Disabled for more than 60 days. [Limit [6] months.]]
[Health Screening Benefit	If one or more covered Health Screening Tests are performed, [$###] per calendar year]

[Face Amount Payable [reduces by [xx%]] [at][on] [and][Benefits][end][at][on][on the following]]

Policy Benefits are limited to the Maximum Issue Amount, or the Face Amount selected by the Covered [Employee], if less.	[Age ##] [Age ##]

[Evidence of Insurability is required if any Face Amount applied for is [$###,###] or more.]

[Family Option:

[Spouse]	[Benefit Limited to] [50] % of the [Exempt] [Employee]'s Benefit]	[$###,###]
[Child(ren)]	[Benefit Limited to] [50] % of the [Exempt] [Employee]'s Benefit]	[$###,###]

[[ELIGIBILITY

[Classes of Eligible [Employees]:]	**[Classes of Eligible Dependents:]**
[Exempt Employees]	[Spouses of Insured Eligible [Employees]]
[Other Named Class]	[Children of Insured Eligible [Employees]]
[Other Named Class]	

[[Eligibility Requirements for Eligible [Employees]]

[In order to Enroll, an Eligible [Employee] must be [Actively at Work (Active Employment)]:

[for [Exempt Employees] Actively At Work means [40] hours per [week]]

[for [Other Named Class] Actively At Work means [40] hours per [week]]

[for [Other Named Class] Actively At Work means [40] hours per [week]]]

[[[Waiting Periods for Eligible [Employees] are as follows:]

[[Exempt Employees] are Eligible to Enroll on Date of Employment]

[[Other Named Class] are Eligible to Enroll after Active Employment for [30 days]]

[[Other Named Class] are Eligible to Enroll after Active Employment for [90 days]]]

[However, if an Eligible [Employee] is not Actively At Work at the end of the Waiting Period, the Waiting Period will be extended until the Eligible [Employee] resumes work in a pattern that will establish Active Employment.]

[Eligible [Employees] must be Age [##] but not more than Age [##].] The Maximum Renewal Age is to Age [##]. [However, an [Employee] who remains Actively At Work after Age [##] will remain an Eligible Employee.]

[Additional Eligibility Requirements for Dependents]

[Waiting Periods for Eligible [Employees] apply to their Eligible Dependents.]

[Spouses of Insured [Employees] must be Age [##] but not more than Age [##].] [A Spouse who is an Eligible [Employee] may be covered as an Insured or a Spouse, but not both.]

[Children of Insured [Employees] must be Age [##] but not more than Age [##].] [A child who is an Eligible [Employee] may be covered as an Insured or a Child, but not both.]

[EFFECTIVE DATES FOR CHANGES IN AMOUNTS OF INSURANCE]

[Increases in the amount of insurance based on Policy provisions will occur [on the first day of the [Calendar Month] following the change].]

[If Evidence of Insurability is not required, increases that You request will occur [on the first day of the [Calendar Month] following the change request].]

[If Evidence of Insurability is required, increases that You request will occur [on the first day of the [Calendar Month] after We approve the Evidence of Insurability].]

[Decreases that You request will occur on [the first day of the [Calendar Month]] following receipt of the written request by the Policyholder.]

[Decreases on account of Age will occur on the [first day of the [Calendar Month]] following the Age change.]]

ELIGIBILITY TO ENROLL

You are Eligible to Enroll when You:

- are a member of a Class of Eligible [Employees] listed on the Schedule; and
- meet the Eligibility Requirements shown on the Schedule.

EFFECTIVE DATE OF INSURANCE

Subject to payment of Premium, insurance starts when You:

- join a Class of Eligible [Employees];
- meet the Eligibility Requirements shown on the Schedule; and
- complete an Enrollment Form, if required.

However, if You do not Enroll, insurance will not become effective until the first day of the [Calendar Month] following a later Enrollment.

We may require You to provide Us with Evidence of Insurability if Enrollment takes place more than [30] days after You first become Eligible.

The Face Amount available to You without Evidence of Insurability is shown on the Schedule.

EFFECTIVE DATE FOR CHANGES IN THE AMOUNT OF INSURANCE

Changes will occur on the dates specified on the Schedule.

BENEFITS

Benefits and Face Amounts selected by the Policyholder and approved by the Company are shown on the Schedule of the Policy.

Benefits shown on this Certificate are available:

- to persons Eligible;
- who have Enrolled for the Benefits;
- are covered under the terms and conditions of the Policy; and
- for whom Premiums are paid.

Changes to the amount of insurance based on Age, Class or other factors agreed to by the Company and the Policyholder are shown on the Schedule.

All Benefits of the Policy are subject to the Benefit Conditions, Limitations and Exclusions provision.

[VASCULAR BENEFITS

Heart Attack Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person is diagnosed with a covered Heart Attack.

Heart Transplant Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person:

- demonstrates Heart Failure; and
- is registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human to human replacement of the whole heart.

Heart Transplant under the Policy includes a heart lung transplant.

Stroke Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person is diagnosed with a covered Stroke.

[Coronary Artery Bypass Surgery Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person has undergone a covered Coronary Artery Bypass Surgery.]]

[Angioplasty

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person has undergone Angioplasty.]]

[CANCER BENEFITS

Invasive Cancer or Malignant Melanoma Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person is diagnosed with a covered Invasive Cancer.

Carcinoma in Situ Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person is diagnosed with a covered Carcinoma in Situ.]

[OTHER CRITICAL ILLNESSES BENEFITS

Major Organ Transplant Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person:

- demonstrates Major Organ Failure; and
- is registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human to human replacement of the failing Major Organ.

Major Organ Transplant does not include:

- Heart Transplant; or
- Heart Lung Transplant.

End Stage Renal Failure Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person is diagnosed with a covered End Stage Renal Failure.

Loss of Vision, Speech or Hearing Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person is diagnosed with a
covered:

- Loss of Vision;
- Loss of Speech; or
- Loss of Hearing.

Coma Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person is diagnosed with a covered Coma.

Severe Burns Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person is diagnosed with covered Severe Burns caused by an Accident.

Permanent Paralysis Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person is diagnosed with a covered Permanent Paralysis caused by an Accident.

[Occupational HIV Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person is diagnosed with an Occupational HIV.]

[Alzheimer's Dementia Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person is diagnosed with Alzheimer's Dementia.]

[Loss of Independent Living Benefit

We will pay this Benefit for a Covered Person when We receive Proof from a Physician that the Loss of Independent Living is permanent and has continued after the end of the [90-180] day Elimination Period. This benefit is payable only once per lifetime per Covered Person.]

[Diabetes Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person is diagnosed with Type I or Type II Diabetes.]]

[RECURRENCE BENEFIT

With the exception of Diabetes, We will pay this Benefit one time if a Covered Person is diagnosed for a second time with one of the named Critical Illnesses for which We paid a Benefit before. We will not pay a Recurrence Benefit for Diabetes. The Benefit is shown on the Schedule. This is subject to the following:

- the second diagnosis must follow the first by more than [12] months;
- the Covered Person must not have received treatment during a [12] consecutive month period between the two diagnoses; and
- the second diagnosis must take place while the Covered Person's coverage is in effect.

For the purposes of this Benefit, "treatment" does not include:

- preventative medications in the absence of disease; or
- routine scheduled follow-up visits to a Physician.

This Benefit is available once for a Covered Person during the entire time that His Certificate is in force.

When this Benefit is paid, it ends for the Covered Person. No Recurrence Benefit will be paid thereafter for recurrence of any Critical Illness of the Covered Person.]

[**ADDITIONAL OCCURRENCE BENEFIT**

We pay one additional benefit upon the diagnosis of a covered condition for which benefits have not been previously paid. The diagnosis must be separated from any other critical illness by at least six months.]

[LOSS OF WORK BENEFIT

We will provide this Benefit if You suffer a Loss of Work that:

- starts more than 30 days after the Effective Date of Insurance; and
- continues for 30 or more consecutive days.

[The 30-day period after the Effective Date of Insurance will be reduced by one day for each day that a Replaced Policy was in force.]

We will waive Premiums of this Certificate. Premiums will be waived as they fall due beginning on the 31st day of the Loss of Work.

We will waive Premiums for a maximum of [six (6) months] during a continuous Loss of Work. Losses of Work separated by less than [six (6) months] are considered continuous.

We will waive Premiums for not more than [12 months] for all Losses of Work occurring while this Benefit is in force.

We will refund any Premium paid but not due.]

[WAIVER OF PREMIUM BENEFIT

We will waive Premiums from the first day of Total Disability when Your Total Disability:

- starts while the Policy and Your Certificate are in force or in the Grace Period;
- starts before the Certificate Anniversary following Your 60th birthday; and
- continues without interruption for at least 60 days.

Waiver will start on the first day of Total Disability. We will waive Premiums:

- as they fall due while You remain Totally Disabled; and
- using the mode of Premium payment that was in effect when Total Disability began.

We will not end a claim if You attempt to return to work for 14 days or less.]

[HEALTH SCREENING BENEFIT

We will pay the amount shown on the Schedule if, during a [Calendar] Year, a Covered Person has one or more of the following tests performed more than 90 days after the Date of Certificate.

- Bone Marrow Testing
- CA-125 (blood test for ovarian cancer)
- Chest x-ray
- Flexible Sigmoidoscopy
- Mammography (including breast ultrasound)
- PSA (blood test for prostate cancer)
- Biopsy for Skin Cancer
- Electrocardiogram (EKG) (including stress EKG)
- Blood Test for Triglycerides
- Fasting blood glucose test
- CA 15-3 (blood test for breast cancer)
- CEA (blood test for colon cancer)
- Colonoscopy
- Hemocult stool analysis
- Pap Smear (including ThinPrep Pap Test)
- Serum Protein Electrophoresis (test for myeloma)
- Stress test (bike or treadmill)
- Lipid Panel (total cholesterol count)
- Oral Cancer Screening using ViziLite, OraTest or other Current Dental Terminology © Code D0431
- Serum cholesterol test to determine level of HDL and LDL.

[The 90-day period will be reduced by one day for each day that a Replaced Policy was in force.]]

PAYMENT OF BENEFITS

We will pay Benefits when We receive Proof of Loss acceptable to Us. Benefits are subject to the Benefit Conditions, Limitations and Exclusions provision.

BENEFIT CONDITIONS, LIMITATIONS AND EXCLUSIONS
A Critical Illness must be diagnosed during the lifetime of the Covered Person.

[Any loss due to a Pre-existing Condition will not be covered if the loss begins within [12] months after the Covered Person's Effective Date of Insurance. [However, Benefits may be paid for a loss due to a Pre-existing Condition of a Covered Person who was covered:

- by a Replaced Policy; and
- by the Policy on its Initial Effective Date.

1. We will review the claim. If the Policy's Pre-Existing Condition Exclusion does not apply, We will pay the Benefits of the Policy.

2. If the Covered Person does not satisfy the Policy's Pre-Existing Condition Exclusion, but can satisfy the Replaced Policy's pre-existing condition exclusion giving credit for all time insured under both policies; then We will pay the lesser of:

   (a) the Policy's Benefit without applying the Pre-Existing Condition Exclusion; or
   (b) the Benefit of the Replaced Policy.

   Any payment under "(a)" or "(b)" above will be in accord with all terms of the relevant policy.

3. If the Covered Person does not satisfy the Pre-Existing Condition Exclusion of the Policy or that of the Replaced Policy, no Benefit will be paid.]

When a named Critical Illness is contributed to or caused by another named Critical Illness, We will pay only one Benefit. The Benefit paid will be the larger. If the Benefits are equal, the [Employee] may choose the Benefit to be paid.

[A Tentative, Clinical or Pathological Diagnosis of Invasive Cancer during the 30-day period after a Covered Person's Effective Date of Insurance is not Covered.] [The 30-day period is reduced by one day for each day that a Replaced Policy was in force.]

[Benefits for Invasive Cancer or Carcinoma in Situ will not be payable based on a Tentative Diagnosis.]

[Except as provided in the Recurrence Benefit,]all Vascular Benefits end when We have paid [100% of] a Covered Person's Face Amount for any of the following:

- Heart Attack;
- Heart Transplant; [or]
- Stroke.]

[When We pay a Benefit for Coronary Artery Bypass Surgery, the Face Amount for other Vascular Benefits is reduced by [25%].]

[When We pay a Benefit for Angioplasty, the Face Amount for other Vascular Benefits is reduced by [10%].]

[Except as provided in the Recurrence Benefit,]all Cancer Benefits end when We have paid [100%]of a Covered Person's Face Amount for Invasive Cancer.

[When We pay a Benefit for Carcinoma in Situ, the Face Amount for Invasive Cancer is reduced by [25%].]

[Except as provided in the Recurrence Benefit,]all Other Critical Illness Benefits end when We have paid [100%] of a Covered Person's Face Amount for any of the following:

- Major Organ Transplant;
- End Stage Renal Failure;
- Loss of Vision, Speech or Hearing;
- Coma;
- Severe Burns;
- Permanent Paralysis;
- Occupational HIV; or
- Alzheimer's Dementia;]

[When We pay a Benefit for Loss of Independent Living, the Face Amount for Other Critical Illnesses Benefits is reduced by [25%].]

[When We pay a Benefit for Diabetes, the Face Amount for Other Critical Illnesses Benefits is reduced by [10%].]

No Benefits of the Policy will be paid for loss that is contributed to, caused by, or occurs during;

- any intentionally self-inflicted injury;
- suicide, or attempted suicide, while sane or insane;
- active duty military service;
- participation in the commission or attempted commission of a felony;
- being intoxicated or under the influence of alcohol, drugs or any narcotic (including overdose) unless administered on, and taken in accordance with, the instructions of a Physician;
- psychosis; or
- alcoholism or drug addiction.

CLAIM PROVISIONS

Notice of Claim

Written notice of Claim must be given to Us within [30] days after the date of a loss. If that is not possible, We must be notified as soon as it is reasonably possible to do so.

When We receive written notice of Claim, We will send claim forms. If the Claim forms are not received within [15] days after the notice is sent, written proof of Claim can be sent to Us without waiting for the forms.

Proof of Loss

Proof of Loss must be given to Us within [90] days after a loss occurs or starts.

If it is not possible to give proof within this time limit, it must be given as soon as reasonably possible. Proof of Loss may not be given later than one year after the time such proof is otherwise required, except if the individual is legally unable to provide it.

Proof of Loss includes a Claim Form or other documents satisfactory to Us.

Proof of Loss may also include statements completed by You and/or Your Covered Dependent, [the Employer] and the attending Physician showing:

- the nature of the loss;
- the date, or inclusive dates, of loss; and
- the cause of loss.

[For the Waiver of Premium Benefit, We may require Proof of Loss on a monthly basis. We will not require such Proof of Loss on a monthly basis when it is no longer reasonably necessary to do so.]

[For the Loss of Work Benefit, Proof of Loss includes documentation from Your Employer and/or union showing that You are Laid Off, Locked Out, or On Strike.]

On request, We will tell the Insured or other claimant what forms or documents are required.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

We will give You or the claimant a Claim Form upon request. You are responsible for any costs for completing the Claim Form.

We may ask for other Proof of Loss from hospitals and Physicians. We will pay the reasonable cost of obtaining these records.

Payment of Claims

Benefits will be paid to You. If You do not live to receive payment, any Benefit will be paid to Your:

- Beneficiary, if one is named; or
- estate.

If Benefits are payable to Your estate or to a Beneficiary who cannot give Us a valid release, We can pay up to $1,000 to someone related to You, by blood or marriage, whom We find is justly entitled to payment. Such a payment made in good faith will discharge Us to the extent of the amount paid.

You may assign proceeds of a Claim. Assignment of a Certificate as collateral security is not allowed.

Time Payment of Claims

Payment will be issued upon receipt of Proof of Loss acceptable to Us but not later than [30] days after receipt of Proof of Loss.

Examination and Autopsy

We, at Our own expense, will have the right and opportunity to have a claimant examined by a Physician of Our choice. This right may be exercised as often as reasonably required.

We, at Our own expense, will have the right to have an autopsy performed in the case of death, where autopsy is not forbidden by law.

Continuation of Insurance

Insurance may be continued under certain conditions when You are no longer an Eligible [Employee]. The Policyholder must treat all [Employees] in the same way when continuing coverage.

As Required by Law or Regulation

The Policyholder will continue insurance on Covered Persons if required to do so by state or federal law or regulation.

The Company does not have nor does it assume, either expressly or impliedly, any responsibility for any such Policyholder obligation.

[For Non-Medical Reasons

The Policyholder may continue Your insurance for up to [twelve (12) months] if You are absent from work due to temporary layoff, suspension of business operations, or Policyholder-approved leave of absence.]

[For Illness or Accidental Injury

The Policyholder may continue Your insurance if You are absent from work due to Total Disability. This continuation will end on the earliest of the following dates:

- [180 days] after Total Disability began;
- [the date from which We approve a Waiver of Premium;] [or]
- the Policy termination date.]

[PORTABILITY

Portability Benefit

Portability allows You to keep the Policy's Benefits at certain times when Your coverage would otherwise end. This is subject to the Benefit Conditions, Limitations and Exclusions.

Coverage is provided under the terms and conditions of the Policy.

When Portability is Available

Subject to the Portability Benefit Conditions and Limitations provision, You may port Benefits when You:

- have been continuously covered by the Policy for at least [6] months;
- are less than Age [70];
- are not Totally Disabled; and
- are no longer Actively At Work as an Employee.

The Policy must be in force on the date that You port coverage.

How to Exercise Portability

You must, within [46] days after the date that Your coverage would end:

- submit written application on a form approved by the Company; and
- pay the first Premium for ported coverage.

Effective Date of Ported Insurance

When the first Premium for ported insurance is paid, coverage will start on the date that coverage under the Policy would have ended.

Premiums and Premium Due Dates

You must pay Premiums to the Company by [monthly bank draft] or other mode of Premium payment that We approve.

After insurance is effective there is a 31-day Grace Period for each Premium due. If the Premium due is not paid, the Grace Period begins on the day of the month that coverage began. Coverage remains in effect during the Grace Period.

The Premium rate and Premium changes applicable to a Class will apply to former Class members who have ported.

We may add a billing fee to the Class rate applicable to ported Certificates.

If you port and Premiums for a Class change, We will provide You at least a [45-day] advance written notice of the change.]

Amount of Insurance

Subject to the Changes to Amount of Ported Coverage provision, insurance provided will be that which was in effect on the day prior to the Effective Date of Ported insurance.

Changes to Amount of Ported Coverage

Benefits provided under the Portability provision cannot be increased.

If You decrease or end a Ported Benefit, any change in Premium will take place on [the first day of the [Calendar Month]] after We receive the request.

When insurance decreases or ends for a Class, the decrease or termination will apply to former members of the Class who have ported.

Termination of Ported Insurance

Ported insurance for You and Your Covered Dependents ends on the earliest of the following dates:

- when You request termination;
- at the end of the Grace Period, if the Premium is not paid;
- when You reach the Maximum Renewal Age;
- a date or Age for termination of insurance for the Covered Person shown on the Schedule;
- for a Spouse or Child, when He or She no longer meets the Policy's definition of Spouse or Child;
- for a Spouse, Age [##];
- for a Child, Age [##];
- on the next Premium due date following Your death;

Portability Benefit Conditions and Limitations

Unless stated, any changes to the Policy apply to ported insurance.

You are not eligible to use this Benefit if Totally Disabled.

[You cannot port while absent from work due to:

- temporary layoff;
- suspension of business operations; or
- Policyholder-approved leave of absence for non-medical reasons.]

You are not eligible to port while Policy coverage is continued based on a state or federal law, regulation or rule.

You are not eligible to Port when the Policy ends.]

TERMINATION OF INSURANCE – COVERED PERSONS
Subject to the Continuation of Insurance [and Portability] provision[s], all insurance ends on the earliest of the following dates:

- [Your retirement;]
- the Maximum Renewal Age shown on the Schedule[, except that if You remain Actively At Work You may continue the coverage];
- the date shown on the Schedule;
- the end of the Grace Period, if Premium for this coverage is not paid;
- the end of the [Calendar Month] when the Covered Person is no longer Eligible;
- the Policy's termination date;
- the end of the [Calendar Month] when We receive a request to end this insurance;
- [the date that a Spouse reaches Age [##];]
- [the date that a Child reaches Age [25]; [or]
- Your death.

[If a Recurrence Benefit is paid for a Covered Person, the Recurrence Benefit for that person ends.]

When Your coverage ends, insurance on other persons covered by this Certificate will also end.

Termination of insurance on a Covered Person or of the Policy is without prejudice to claims that occur or start prior to the date of termination.

GENERAL PROVISIONS

Agreements and Policy Changes

No change in the Policy shall be valid unless made by endorsement or amendment. Such a change is valid only if signed by Our Chairman, Chief Executive Officer, President, a Vice President or the Secretary.

No other person can waive any Policy terms or make any agreements about the Policy that are binding on Us.

Assignment

You may assign proceeds of a Claim.

Assignment of a Certificate is not allowed.

We are not responsible:

- for the validity of any Assignment; or
- to honor any Assignment unless it is given to Us with any claim subject to the Assignment.

Our payment in good faith as outlined above will fully discharge Us with respect to the amount(s) paid.

Beneficiary, Change of Beneficiary

Benefits will be paid as stated in the Payment of Claims provision.

You may add or change the Beneficiary by filing a form with the Policyholder.

We are not:

- responsible for the validity of any Beneficiary designation, or
- required to honor any Beneficiary designation unless it is given to Us with any affected claim.

Clerical Error

No Clerical Error by the Policyholder will:

- delay the Effective Date of a Covered Person's insurance;
- end insurance otherwise validly in force; or
- continue insurance otherwise validly terminated.

Conformity With State Statutes

Any Policy wording that, on the Initial Effective Date, is in conflict with the statutes of the Situs State is hereby amended to meet the minimum requirements of such statutes.

[Date of Birth [and Gender]

If a Covered Person's date of birth [or gender] is misstated, We will adjust the Benefits payable. The Benefits will be those which We would have issued based on the correct information.]

Entire Contract

The Policy, the Application, Enrollment forms and Evidence of Insurability as well as any endorsements and amendments shall make up the entire contract.

Statements made by the Policyholder or Insured individuals shall be deemed representations and not warranties.

Evidence of Insurability

We may require evidence that a person meets our underwriting standards for this insurance.

[Fiduciary

For purposes of the Employee Retirement Income Security Act of 1974 (ERISA), the Policyholder is the:

- Plan Sponsor;
- Plan Administrator; and
- Named Fiduciary.

Neither the Company, its parent nor any of its affiliates is the Plan Sponsor, Plan Administrator or Named Fiduciary.

The Company does not have nor does it assume, either expressly or impliedly any responsibility for the Policyholder's obligations or compliance under:

- ERISA;
- COBRA; or
- any other applicable federal or state law, regulation or rule.]

Grace Period

The Policy has a Grace Period of thirty-one (31) days for the payment of any Premium due except the first.

During the Grace Period, the Policy is in force, unless the Policyholder gives Us written notice to cancel it before the end of the Grace Period. The Policyholder shall be liable to Us for the payment of a pro-rata premium for the time the Policy was in force during the Grace Period.

Incontestability

The validity of the Policy will not be contested except for nonpayment of Premiums after it has been in force for [two (2)] years from its Initial Effective Date.

No statement made by any person insured shall be used in any contest unless a copy of the statement is or has been furnished to:

- the person insured; or,
- in the event of death or incapacity of the person insured, to His or Her beneficiary or personal representative.

Except for claims incurred within [two (2)] year[s] after a Covered Person's Effective Date of Insurance, no statement made by any person insured when applying for insurance will be used to contest the validity of that insurance after:

- the insurance has been continuously in force for [two (2)] years during the lifetime of the person insured; and
- unless it is contained in a written form signed by the Insured.

This provision shall not preclude the assertion at any time of defenses based upon Policy provisions that relate to eligibility for coverage.

Legal Actions

Legal action cannot be taken against Humana Insurance Company:

- Sooner than 60 days after due Proof of Loss has been filed; or
- 3 years after the time written Proof of Loss is required to be filed according to the terms of the Policy.

DEFINITIONS

For the purposes of the Policy when these words are used in the Policy, they have the meanings stated.

Accident means a sudden, unexpected, violent and external event that causes bodily Injury to a Covered Person.

[Actively At Work (Active Employment) means You must be working:

- on a full-time basis and paid regular earnings;
- at least the minimum number of hours shown in the Schedule;
- at the Employer's usual place of business; or
- at a location to which the Employer's business requires You to travel.

You must be considered Actively At Work if You were actually at work on the day immediately preceding:

- a weekend;
- holidays;
- paid vacations;
- any non-scheduled work day;
- excused leave of absence (except medical leave and lay-off); or
- emergency leave of absence (except emergency medical leave required by Your Illness or Injury).

[If You are classified as a[part-time][or][temporary] worker by Your [Employer], You are not Actively At Work except as agreed between the Policyholder and the Company.]

If You are On Strike, You are [not] Actively At Work [except] [as] agreed by the Policyholder and the Company.

[The Active Employment must be for an Employer that has a workforce of Employees who are Eligible for Policy Coverage.]]

Activities of Daily Living refer to the Basic Activities of Daily Living. They are:

a) Bathing - the ability to wash oneself, either in a tub or shower or by sponge bath, with or withoutquipment or adaptive devices.
b) Continence - the ability to voluntarily control bowel and bladder function, or, in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.
c) Dressing - the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn, and to fasten or unfasten them.
d) Eating - the ability to get nourishment into the body by any means once it has been prepared and made available to you.
e) Toileting - the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene and to care for clothing.
f) Transferring - the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.

Alzheimer's Dementia means the loss of intellectual capacity involving impairment of memory and judgment as measured by cognitive and neuroradiological tests (e.g. CT scan, MRI, PET of the brain). It must result in significant reduction in mental and social functioning such that the Insured Person requires Substantial Assistance in performing at least three of the six Activities of Daily Living (as defined in this Certificate). No other dementing organic brain disorders or psychiatric illnesses shall meet the definition of Alzheimer's Dementia, nor will they be considered a Specified Critical Illness. Alzheimer's Dementia must be diagnosed by a Physician board certified in Neurology.

Age means the Age of a Covered Person on His or Her last birthday as of the Initial Effective Date. If coverage is effective after the Initial Effective Date, Age means age as of the last birthday preceding the request for insurance coverage.

[Association means an entity that:

- has been actively in existence for at least [5] years;
- has been formed and maintained in good faith for purposes other than obtaining insurance;
- does not condition its membership on any health status-related factor relating to an individual (including an employee of an employer or a dependent of any employee);
- makes insurance coverage it offers available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member);
- does not make insurance coverage it offers available other than in connection with a member of the association; and
- meets any additional requirements that may be imposed under laws of the Situs State.]

Benefit Group means a set of Critical Illnesses that is shown on the Schedule for which the Policy pays Benefits.

[Calendar Month means any of the named months, January through December.]

[**Calendar Year** means a 12 month period, [January 1 through December 31.]]

Carcinoma In Situ means a diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Carcinoma in Situ includes early prostate cancer diagnosed as stages I or II or equivalent staging.

Carcinoma in Situ does not include:

- Malignant melanoma of less than 1.0 mm. maximum thickness as determined by histological examination using the Breslow method;
- other skin malignancies;
- pre-malignant lesions (such as intraepithelial neoplasia); or
- benign tumors or polyps.

Carcinoma in Situ must be identified pursuant to a Pathological or Clinical Diagnosis. Pathological or Clinical Diagnosis must occur after the Effective Date of Insurance.

[Child (Children) means a person who is primarily dependent upon and living with You in a permanent parent-child relationship and a:

- natural or adopted child of You or Your Spouse;
- Child placed with You for adoption or a minor for whom the Eligible Employee has filed a petition to adopt; or
- Your stepchild.

Child does not include a:

- person not meeting the above Child definition;
- Child living outside of the United States (unless living with You); or
- Child on active military duty for a period in excess of [30] days.]

[**Class** means a group of persons that We and the Policyholder have agreed to insure.]

Clinical Diagnosis means a clinical identification of Invasive Cancer or Carcinoma in Situ based on history, laboratory study and symptoms. We will pay benefits for a Clinical Diagnosis only if:

- a pathological diagnosis cannot be made because it is medically inappropriate or life threatening;
- there is medical evidence to support the diagnosis; and
- a Physician is treating the Covered Person for Cancer.

Cognitive Impairment and **Cognitively Impaired** mean that the Insured Person has deterioration or loss in his or her intellectual capacity which requires another person's assistance or verbal cueing to protect the Insured Person or others as measured by clinical evidence and standardized tests which reliably measure his or her impairment. Such loss in intellectual capacity can result from Sickness, Alzheimer's Disease or similar forms of senility or irreversible dementia.

[**Coma** means a state of complete and continuous unconsciousness not less than [24-96] hours in duration which exhibits an inability to be aroused or to respond to external stimuli aside from primitive avoidance reflexes.

The diagnosis of Coma must be made by a board-certified Neurologist.

Benefits are not payable for medically-induced comas.

Payment of benefit is based upon Date of Diagnosis made after the Effective Date of Insurance.]

[Coronary Artery Bypass Surgery means major surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts on the advice of a cardiologist or cardiothoracic surgeon.

Diagnosis of coronary heart disease must be made by accepted angiography testing.

The following procedures are not considered coronary artery by-pass surgery: balloon angioplasty, laser embolectomy, atherectomy, stent placement, or other non-surgical procedures.

Payment of benefits is based upon Date of Diagnosis made after the Effective Date of Insurance.]

[Covered Employee means the Eligible Employee, when covered by the Policy.]

[Covered Employee also means a person who has ported coverage as allowed by the Portability provision.]

[Covered Member means the Eligible Member, when covered by the Policy.]

[Covered Member also means a person who has ported coverage as allowed by the Portability provision.]

Covered Person means an eligible [Employee] or Eligible Dependent who is covered under the Policy. Persons eligible for coverage are shown on the Schedule.

[**Credit Union** means an institution that is chartered to operate as a Credit Union by the National Credit Union Administration or by a state regulatory body.]

Critical Illness means:

[• Heart Attack;
• Heart Transplant; [or]
• Stroke[;] [or]
• [Coronary Artery Bypass Surgery;]]
[• Invasive Cancer or Malignant Melanoma; [or]
• Carcinoma in Situ[;]] [or]
[• Major Organ Transplant;
• End Stage Renal Failure;
• Loss of Vision, Speech or Hearing;
• Coma;
• Severe Burns;
• Permanent Paralysis;
• Occupational HIV
• Alzheimer's Dementia;
• Loss of Independent Living; or
• Diabetes (Type I or II).]

Date of Diagnosis means the earliest of the date of:
• Tentative Diagnosis;
• Clinical Diagnosis; or
• the day the tissue specimen, culture and/or titer(s) are taken, upon which the Tentative or Pathological Diagnosis of Invasive Cancer or Carcinoma in Situ is made.

Eligible Dependents means a Spouse, His or Her Child(ren) and the Child(ren) of an Eligible [Employee].

We must approve eligibility of the Spouse and Child(ren) of an [Employee].

Each such person must meet the Eligibility requirements shown in the Schedule.

If a Child is covered by the Policy, the Child's Eligibility will not end if the Child is and remains:

• unmarried;
• incapable of self-sustaining employment due to mental incapacity or physical handicap; and
• chiefly dependent on the [Employee] or Spouse for support.

However, in no event will Eligibility or coverage of any Child continue beyond the date that the [Employee's] coverage ends.

The [Employee] must furnish Us with proof of physical or mental incapacity. Thereafter, We may require proof, but not more frequently than annually.

[Eligible Employee means a person who:
• is in Active Employment of the Policyholder; and
• meets the Enrollment Eligibility, Qualification Period and Maximum Renewal Age provisions shown in the Schedule.]

[Eligible Person means someone who:

• is a Member in good standing of the Policyholder; and
• meets any other Eligibility Requirements for Eligible Members shown on the Schedule.]

Elimination Period means the number of consecutive days before benefits become payable.

[Employer means an entity that employs a workforce of persons in Active Employment. Employer includes any division, subsidiary or affiliated company named in the Application.]

End-Stage Renal Failure means End Stage Renal disease which:

- results in chronic irreversible failure of both kidneys to function; and
- which requires a Covered Person to undergo regular renal dialysis at least weekly or a kidney transplant.

The diagnosis of End Stage Renal Failure must be made by a Physician, after the Effective Date of Insurance .

Enroll means application by an [Eligible Employee] for Policy coverage. By agreement between the Company and the Policyholder, Enrollment may:

- require completion of an Enrollment Form by the [Eligible Employee];
- be automatic, in which case it is not necessary for the [Eligible Employee] to complete an Enrollment Form; and
- require Evidence of Insurability.

Evidence of Insurability means a form acceptable to Us showing that a person meets Our requirements for coverage under the Policy.

Heart Attack (Myocardial Infarction) means the death of a portion of the heart muscle resulting from blockage of one or more coronary arteries. A covered Heart Attack is one that:

- displays new EKG changes consistent with and supporting the diagnosis of Heart Attack;
- exhibits elevation of cardiac biomarkers / enzymes (such as Troponin and Creatine Kinase) above generally accepted laboratory levels of normal (in case of CPK, a CPK-MB measurement must be used);
- is confirmed by imaging studies such as thallium scans, MUGA scans or stress echocardiograms; and
- occurs after the Effective Date of Insurance.

The Date of Diagnosis is the date of ischemic death of an area of the heart muscle, as confirmed by the above criteria. Diagnosis is to be made based on generally accepted principles of medicine at the time the diagnosis is made.

The following are not considered as a Heart Attack:

- an EKG change consistent with transient ischemic change;
- angina;
- chance finding of EKG changes suggestive of a previous Heart Attack; or
- the death of the heart muscle coincidental with death from other causes.

Heart attack that occurs during or within [24] hours after a cardiac or coronary artery procedure is excluded.

Payment of benefit is based upon Date of Diagnosis made after the Effective Date of Insurance.

Heart Failure means clinical evidence showing disease of or injury to the heart that is, by generally accepted medical standards, sufficient to require a human to human replacement of the whole heart.

The diagnosis of Heart Failure must be made after the Effective Date of Insurance.

Heart Transplant means that a Covered Person:

- demonstrates Heart Failure; and
- is registered with and on the waiting list of the United Network for Organ Sharing or its recognized successor for a human to human replacement of the whole heart.

Illness means sickness or disease of a Covered Person.

Initial Effective Date means the date that coverage begins under the Policy.

Injury means the bodily harm resulting directly from an Accident and independently of all other causes.

Insured means an [Eligible Employee] who is covered by the Policy.

Invasive Cancer means a malignant tumor characterized by:

- the uncontrolled growth and spread of malignant cells; and
- the invasion of local or distant tissue.

This includes Leukemia and Lymphoma.

Payment of Benefit is based upon Date of Diagnosis. The diagnosis must be a Pathological Diagnosis, and must be made more than [30] days after the Effective Date of Insurance. We will accept a Clinical Diagnosis in place of a Pathological Diagnosis only if:

- a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening;
- there is medical evidence to support the diagnosis; and
- a physician is treating the Insured for cancer.

We will not pay Benefits based on a Tentative Diagnosis.

The following are not considered Invasive Cancer for purposes of this Benefit:

- Carcinoma in Situ;
- All skin cancers, unless there is evidence of metastasis;
- Malignant melanoma of less than 1.0 mm. maximum thickness as determined by histological examination using the Breslow method; or

[Laid Off means that Your job has been ended or suspended by Your Employer due to:

- a decrease in output by the Employer;
- a decrease in staff due to economic conditions;
- a reorganization that eliminates Your job; or
- a reorganization that eliminates the Employer's need for Your job skills.

Laid Off does not include termination for cause or because You are no longer physically able to perform the job.]

Locked Out means that Your place of employment has been shut down by Your employer during a labor dispute. The Lockout must be lawful.

[Loss of Hearing means clinically-proven irreversible loss of hearing in both ears, with an auditory threshold of more than [90] decibels, as a result of Illness or Injury that has continued without interruption for a period of at least six (6) consecutive months after diagnosis.

No benefit will be paid if, in general medical opinion, surgery, a hearing aid, device, or implant could result in the partial or total restoration of hearing.

The diagnosis must be made by physical examination by an audiologist after the Effective Date of Insurance.

[For Optional Child Benefit, the Covered Person must be age three (3) years or older at the time of diagnosis.]]

Loss of Independent Living means being unable to perform two or more Activities of Daily Living without Stand-by Assistance or being Cognitively Impaired.

[**Loss of Speech** means the clinically-proven total, permanent and irreversible loss of the ability to speak as a result of Illness or Injury or disease that has continued without interruption for a period of at least six (6) consecutive months.

No benefit will be payable if, in general medical opinion, surgery, a device or implant could result in the partial or total restoration of speech.

The diagnosis must be made by physical examination by a speech pathologist after the Effective Date of Insurance.

[For Optional Child Benefit, the Covered Person must be age three years (3) or older at the time of diagnosis.]]

[**Loss of Vision,** means clinically-proven, irreversible reduction of sight in both eyes as a result of Illness or Injury. The corrected visual acuity must be:

- less than [20/200];or
- a visual field restriction to [20] degrees or less in both eyes.

There must be clear proof that blindness was due to Illness or Injury, and that the condition has continued without interruption for a period of at least six (6) consecutive months after diagnosis.

No benefit will be paid if, in general medical opinion, surgery, a device, or implant could result in the partial or total restoration of sight.

The diagnosis must be made:

- by physical examination by an ophthalmologist; and
- after the Effective Date of Insurance.

[For Optional Child Benefit, the Covered Person must be age three years (3) or older at the time of diagnosis.]]

[Loss of Work means that the Insured is Laid Off, Locked Out or On Strike, or any combination of the three.]

[Major Organ Failure means clinical evidence showing disease of or injury to one of the following Major Organs that is, by generally accepted medical standards, sufficient to require a human to human replacement of the whole organ:

- liver;
- kidney;
- pancreas or pancreas-kidney; or
- lung or lungs.]

The diagnosis of Major Organ Failure must be made after the Effective Date of Insurance.

Major Organ Transplant means that a Covered Person:

- demonstrates Major Organ Failure; and
- is registered with and on the waiting list of the United Network for Organ Sharing or its recognized successor for a human to human replacement of the failing organ.

[Member means a person who is in a Class shown on the Schedule [and in good standing as defined by the [Association's] requirements and bylaws.]]

[Occupational HIV means that the Covered Person initially contracted and was diagnosed with Human Immunodeficiency Virus (HIV) after the Date of Certificate. Benefits will only be paid if all of the following conditions are met:

- the cause of the HIV must be from an Accidental needle stick/sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid which occurred during the twelve (12) months preceding diagnosis, after the Effective Date of Insurance and while His insurance is in force;
- the Accident must have occurred while the Covered Person was following the normal occupational duties and reported in accordance with the established occupational procedures for such Accidents;
- the Covered Person must have undergone a blood test within five (5) days of the Accident which indicated the absence of HIV or antibodies to such a virus; and
- within twelve (12) months of the Accident, the Covered Person must undergo a follow up blood test indicating the presence of HIV or antibodies to such a virus.]

[On Strike (Strike) means that You and other Employees acting together

- have ceased work, or
- are refusing to work or to continue to work for Your Employer.

The Strike must be authorized under the rules of a union or unions representing You and other striking Employees.

The union or unions authorizing the strike must be recognized by the Your Employer for collective bargaining purposes.]

The Strike must be lawful and must not take place while a labor contract is still in effect.]

Pathological Diagnosis means identification of cancer based on a microscopic study of fixed tissue or preparations from the hemi (blood) system.

The diagnosis must be:

- made by a certified pathologist; and
- in keeping with the standards set by the American Board of Pathology.

Permanent Paralysis means only:

- Hemiplegia;
- Paraplegia; or
- Quadriplegia.

The loss must:

- be expected to be permanent;
- have been present continuously for at least [180] days
- be caused by Injury sustained in an Accident occurring after the Effective Date of Insurance;
- have been first diagnosed after the Effective Date of Insurance;
- be evidenced by the total and irreversible loss of use of two or more limbs; and
- be marked by loss of muscle function in two arms, two legs, or one arm and one leg.

Paralysis does not include paralysis that results from a Stroke.

Physician means a medical doctor or other person recognized by law or regulation in the state where services are rendered as a Physician. The person must be licensed and practicing in the United States.

Physician does not include:

- the Insured
- a person related to the Insured by blood or marriage; or
- a medical doctor or other person practicing outside of the United States.

Policy means the group Policy issued to the Policyholder.

[Policy Month means a period of time:

- beginning on the day of the month corresponding to the Initial Effective Date; and
- continuing through the end of the preceding day in the next Calendar Month.]

[Policy Year Means a period of time:

- beginning on the Initial Effective Date or its anniversary; and
- continuing through the end of the day preceding the next anniversary.]

Policyholder means the entity so named on the Policy face page.

Pre-existing Condition means any of the following which a Physician has treated or for which a Physician has advised treatment of the Covered Person within 12 months before the Covered Person's Effective Date of Insurance:

- [Heart Attack;] [or]
- [Stroke][;]
- [Invasive Cancer;] [or]
- [Carcinoma in Situ;]
- [Coma;]
- [End-Stage Renal Failure;]
- [Loss of Vision, Speech or Hearing;]
- [Severe Burns;]
- [Permanent Paralysis;][or]
- [Occupational HIV].

Pre-existing Condition also means [any of] the following which a Physician has treated or for which a Physician has advised treatment (by transplant, bypass surgery, medication or otherwise) of the Covered Person within 12 months before the Covered Person's Effective Date of Insurance:

- [failure of the liver, kidney(ies), pancreas, or lung(s);]
- [failure of the heart;] [or]
- [coronary artery disease][.]

Pre-existing Condition also means that a Physician has given a Tentative Diagnosis of Invasive Cancer or Carcinoma in Situ of the covered Person within [12] months before the Covered Person's Effective Date of Insurance.

[Pre-existing Condition also means a condition causing Total Disability which a Physician has treated or for which a Physician has advised treatment of the [Employee] within 12 months before the [Employee]'s Effective Date of Insurance.]

Proof means evidence satisfactory to Us for insurability or for other matters which require Proof.

Renal Failure means End Stage Renal Failure.

Replaced Policy means a policy or certificate, the premiums for which are paid by or through the Policyholder. It must:

- have a paid-to date within [60] days of the Policy's Date of Application;
- be replaced by the Policy; and
- end upon issue of the Policy.

At Our request, the Policyholder must give Us Proof about a[n] [Employee]'s Replaced Policy.

Schedule means page(s) so labeled in the Policy and this Certificate.

[Severe Burns means that the Covered Person has sustained third degree burns covering at least [20%] of the surface area of His body. Third degree means the destruction of the skin through the entire thickness or depth of the dermis and the layer of tissue below the skin (subcutaneous tissue). The diagnosis of Severe Burns must be made by a physician board-certified in Plastic Surgery and after the Effective Date of Insurance.]

Spouse means**[:]**

[1.] the person recognized as Your husband or wife under the laws of the state in which You live[:] [or]

[2.] [the person recognized by Your state of residence as[:]

- [Your Domestic Partner [(California)];]
- [a party to a Civil Union with You [(Connecticut)][,][(New Jersey)][,][and][(Vermont)] ;]
- [Your Reciprocal Beneficiary [(Hawaii)]; or

- [someone for whom We must provide the coverage of the Policy on a spousal equivalent basis under the laws or regulations of Your state.]]

[When We provide coverage under this definition “2”, We will continue to provide coverage after You or Your Spouse moves to a state that does not recognize the relationship described.]

[We will not continue to provide coverage under these definitions “1” and “2” for the Spouse when a legal action ends a relationship described.]

[3.] [persons who, by written agreement between the Company and the Policyholder, may be covered by the Policy on a spousal equivalent basis.]

The Policy will at no time cover more than one person as Your Spouse.

Stand-By Assistance means the Insured Person requires the presence of another human being to ensure that all or part of an Activity of Daily Living can be completed or to ensure his or her safety.

Strike, see the Definition of “On Strike.”

Stroke, or cerebrovascular accident (CVA), means death of brain tissue due to a cerebrovascular event resulting in neurological damage including infarction, hemorrhage or embolization of brain tissue from an extra cranial source for at least 60 days.

Stroke does not mean a transient ischemic attack, transient global amnesia, chronic cerebrovascular insufficiency, attacks of vertebrobasilar ischemia or a cerebrovascular event resulting from Accidental Injury.

Diagnosis of a Stroke must be based on all of the following criteria;

- documented neurological impairment or deficits;
- evidence of brain tissue damage shown by neuroimaging (CT, MRI, or PET Tomography or similar test);
- permanent neurological deficit measured three months or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome; and
- which was made after the Effective Date of Insurance.

Substantial Assistance means that physical assistance from another person is required to perform one or more of the Activities of Daily Living (ADLs) as defined in the Definitions section of this policy.

Tentative Diagnosis means a diagnosis of Invasive Cancer or Carcinoma in Situ based upon dated medical records.

Totally Disabled (Total Disability) means, for the first [24] months of a disability, that You are:

- unable to perform the substantial and material duties of Your regular occupation;
- not working in any other occupation; and
- under the care of a Physician for the disability.

[After [24] months of Total Disability, Totally Disabled means that You are:

- unable to perform the duties of any gainful occupation for which You are reasonably fitted by training, education or experience; and
- under the care of a Physician for the disability.]

We will not require care of a Physician when it is no longer needed for the sound medical care of the condition causing Total Disability.

Type I Diabetes means the body fails to produce insulin and the Insured requires insulin replacement.

Type II Diabetes means the body becomes resistant to the effects of insulin or doesn’t make enough insulin.

We, Us, Our and **Company** all mean Humana Insurance Company.

You, Your mean the covered [Employee]. These words appear in the Certificates.

Any reference to “He,” “Him” or “His” will also refer to “She” or “Her,” “They,” “Them” or “Their.”

POLICYHOLDER APPLICATION FOR
GROUP CRITICAL ILLNESS COVERAGE
Humana Insurance Company
1100 Employers Boulevard, Green Bay, Wisconsin 54344

ADMINISTERED BY:
Bay Bridge Administrators, LLC
P.O. Box 161690, Austin, TX 78716
800-845-7519

Name of Employer:		Tax ID #	Group #
Address:	City:	State:	Zip Code:
Email Address:	Phone Number:		Fax Number:
Contact Person:			
Nature of Business:		Effective Date of Coverage:	
Initial Enrollment: Start Date:		Stop Date:	
Waiting Period (if any) _____ Days			

Eligible Classes:
All active employees working a minimum of _____ regularly scheduled hours per week, per year.
(A minimum of [17.5] hours per week is required.)
[Other Named Class]
Are there any special eligibility or employee class requirements or restrictions? If so, please describe: _____
SIC Code_____

Number of eligible employees [ ]

Employee participation requirement for guaranteed issue [ ]

Minimum number of lives if not guaranteed issue [ ]

Plan Applied For:

[BASE PLAN WITH OPTIONS	
Vascular	**[Employee Benefit Amount**
Heart	_____
Heart Transplant	([$5,000] to [$100,000])
Stroke	
Coronary Artery Bypass Surgery (25%)	
Angioplasty (10%)	**Spouse Benefit Amount**
Cancer	_____
Invasive Cancer or Malignant Melanoma	([$5,000] to [$100,000])
Carcinoma in Situ (25%)	
Other Critical Illnesses	
Major Organ Transplant	**Child Benefit Amount**
End Stage Renal Failure	_____
Coma	([$5,000] to [$100,000])
Severe Burns	
Permanent Paralysis due to Accident	
Occupational HIV Benefit	
Loss of Vision, Speech, or Hearing (optional)	
Alzheimer's Dementia (25%)(optional)	
Loss of Independent Living (25%)(optional)	
Diabetes (Type 1 or II) (10%)(optional)	
Health Screening Benefit	_____ ($50 - $150)
Strike Waiver Rider]	

Is this a replacement of similar coverage: Yes No
Previous Company:

_____

Termination Date of Prior
Plan:_____

Note: This Policy is not intended to replace comprehensive major medical insurance. The Acceptance letter will confirm your Policy selections.

Rates: Employee Only: _____ _____

Employee and Spouse: _____ _____

Employee and Children: _____ _____

Employee and Family: _____ _____

It is understood and agreed that this application shall be attached as a part of the Policy applied for, and that no insurance shall be effective until approved by Humana Insurance Company at its home office.

I understand that Critical Illness covered persons are covered by group insurance benefits. The group insurance benefits vary depending on plan selected. These benefits are provided under a group insurance policy underwritten by Humana Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate which includes, but is not limited to, limitations for pre-existing conditions. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is a Critical Illness plan that provides for limitations to the coverage. The limitations are disclosed in the policy and certificate which are made available at the time of enrollment.

By the signature below of its duly authorized representative, the proposed Policyholder hereby applies for Humana Insurance Company Group Critical Illness Insurance; and the proposed Policyholder understands and agrees that the Policyholder and the Covered Persons shall be subject to the provisions set forth herein.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at:_____ By: _____
(City, State) (Authorized Signature/Title)

On: _____ For:
_____
(Date)

By: _____
(Printed Agent/Broker Name)

_____
(Signature of Agent/Broker)

ENROLLMENT FORM FOR GROUP CRITICAL ILLNESS COVERAGE
Humana Insurance Company
1100 Employers Boulevard, Green Bay, Wisconsin 54344

ADMINISTERED BY:
Bay Bridge Administrators, LLC
P.O. Box 161690, Austin, TX 78716
800-845-7519

NAME LAST	FIRST	MIDDLE	DATE OF BIRTH

STATE OF BIRTH	OCCUPATION	DATE OF HIRE	SOCIAL SECURITY NUMBER

MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE NUMBER

Complete for Family Coverage:

FIRST	LAST	DOB	AGE	SEX
SPOUSE				
CHILD				
CHILD				
CHILD				
CHILD				
CHILD				

[POLICYHOLDER]	[GROUP POLICY NUMBER]	[DATE OF HIRE]	[AVERAGE WEEKLY HOURS]	[BUSINESS PHONE]
[Yes, I want the Critical Illness Coverage offered by the [Policyholder].] Total Deduction_____ (monthly, semi-monthly, weekly, bi-weekly, other_____)		[Select type of Coverage Eligible Person Eligible Person + Spouse Eligible Person + Child Eligible Person + Family		

[Are you currently working a minimum of [17.5] hours per week? ☐ Yes ☐ No]

[Has any person to be insured used tobacco in any form in the last 12 months? ☐ Yes ☐ No If "yes," name(s) and usage:_____]

[No, I do not want coverage. I understand that if I want coverage at a later date, I will be required to provide evidence of insurability to Humana Insurance Company and my application for coverage may be declined by Humana Insurance Company.

_____ _____]
Signature, if declining coverage Date

I hereby authorize my Employer _____ to reduce my salary by the Total Deduction and forward this amount to Humana Insurance Company. The Total Deduction is calculated as to produce the premiums as determined by my selection of coverage. I further authorize my employer to adjust my deduction based on any change in rate unless I notify them in writing to terminate my deduction.

I hereby declare that I am in an eligible class of the Policyholder. I affirm that all information given by me on this form is true and complete. I have read, or had read to me, the completed application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____ _____
Enrollee Signature Date

EVIDENCE OF INSURABILITY APPLICATION FOR
GROUP CRITICAL ILLNESS COVERAGE
Humana Insurance Company
1100 Employers Boulevard, Green Bay, Wisconsin 54344

ADMINISTERED BY:
Bay Bridge Administrators, LLC
P.O. Box 161690, Austin, TX 78716
800-845-7519

Late Enrollee Enrollee Not Subject to Guaranteed Issue

PROPOSED INSURED LAST	FIRST	MIDDLE	HEIGHT	SEX	DATE OF BIRTH
STATE OF BIRTH	OCCUPATION	DATE OF HIRE	WEIGHT	SOCIAL SECURITY NUMBER	
MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE NUMBER	

Complete for Family Coverage:

FIRST	LAST	DOB	SEX	HEIGHT	WEIGHT
SPOUSE					
CHILD					
CHILD					
CHILD					
CHILD					
CHILD					

[POLICYHOLDER]	[GROUP POLICY NUMBER]	[DATE OF HIRE]	[AVERAGE WEEKLY HOURS]	[BUSINESS PHONE]

[Yes, I want the Critical Illness Coverage offered by the [Policyholder.]	[Select type of Coverage: Eligible Person Eligible Person + Spouse Eligible Person + Child/Children Eligible Person + Family] Benefit Amount_____ Total Deduction_____ [monthly, semi-monthly, weekly]

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[Are you currently working a minimum of [17.5] hours per week? ☐ Yes ☐ No]

HEALTH QUESTIONS:

1) Has any person to be insured been tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?
☐ Yes ☐ No If "yes," name(s) and condition: _____

2) a) Has any person to be insured had or is now being treated by a licensed medical provider for: a stroke; a heart attack; a heart condition; heart trouble or any abnormality of the heart (including artery disease)?
☐ Yes ☐ No If "yes," name(s) and condition: _____

b) Has any person to be insured in the last year had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?
☐ Yes ☐ No If "yes," name(s) and condition: _____

3) a) Has any person to be insured, in the last 2 years, seen a physician (other than for colds, flu, normal pregnancy or a routine physical with no unfavorable results), been treated for, or been told by a licensed medical provider that he/ she has: diabetes, emphysema, epilepsy, hepatitis, mental or nervous illness, ulcers, any disorder of the central nervous system (to include muscular dystrophy or multiple sclerosis); Parkinson's disease, lupus; rheumatoid arthritis; fibromyalgia; chronic fatigue syndrome; any disorder of the heart, kidneys, liver, lungs, or pancreas; paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or stroke?
☐ Yes ☐ No If "yes," name(s) and condition:

_____

b) Has any person to be insured, in the last 2 years, had or been treated by a licensed medical provider for Stress Related Chest Pains or Angina?
☐ Yes ☐ No If "yes," name(s) and condition:_____

c) Has any person to be insured, in the last 2 years, been treated for or counseled by a licensed medical provider for alcohol or drug abuse? ☐ Yes ☐ No If "yes," name(s) and condition:

_____

d) Has any person to be insured had any medical or surgical procedures (including major organ transplant) advised or recommended by a doctor but done not at this time? ☐ Yes ☐ No If "yes," name(s) and condition:

_____

e) Has any person to be insured received any advice, treatment, or consultation by a licensed medical provider for Alzheimer's disease, dementia, senility, or organic brain syndrome?
☐ Yes ☐ No If "yes," name(s) and condition: _____

4) Has any person to be insured , in the last 5 years, been treated (to include, but not limited to, medication usage) or diagnosed with any history of Pre-Diabetes, Metabolic Syndrome, Latent Autoimmune Diabetes in Adults, Hyperglycemia, Foot or Leg Ulcers? ☐ Yes ☐ No If "yes," name(s) and condition: _____

5) Has any person to be insured had a blood sugar reading of 200 or higher or A1C of 8 or higher more than once within the last year? ☐ Yes ☐ No If "yes," name(s) and condition: _____

6) To the best of your knowledge and belief, has any person to be insured or ANY 2 of their natural parents or natural siblings been diagnosed with the same disease before age 60, based on this list: heart disease, stroke, diabetes, cancer, kidney disease, or multiple sclerosis?☐ Yes ☐ No If "yes," name(s) and condition: _____

7) Has any person to be insured used any form of tobacco in the last 12 months? ☐ Yes ☐ No If "yes," name(s) and usage:_____

Other health insurance coverage in force: (List Company name, if known.)

I hereby declare that I am in an eligible class of the Policyholder. I have personally reviewed all of my answers to the questions on this application and certify that all of the information I have provided is true, complete and correct. I agree that it is my responsibility to provide truthful, complete and correct information. I certify I fully understand the questions asked. I agree that any misstatements or failure to report information may be used as the basis of rescission or reformation of coverage for me or my dependents.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____ _____
Enrollee Signature Date

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
Company Tracking Number:	*HIC GP CI 10/11*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.001 Critical Illness*
Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	12/20/2011

Comments:

Attachment:

Cert of Comp. with Rule 19 Group CI.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	12/20/2011

Comments:

see form schedule tab

		Item Status:	Status Date:
Satisfied - Item:	Humana Insurance Company	Approved	12/20/2011

Comments:

Attachment:

Humana Insurance Company Authorization letter.pdf

Certificate of Compliance with
Arkansas Rule and Regulation 19

Insurer: Humana Insurance Company

Form Number(s): HIC-GP-CI-POL10/11, HIC-GP-CI-CERT-AR 06/11, HIC-CI-EE-EF 6/11, HIC-CI-ERAPP 6-/11, HIC-CI-EOI-APP 10/11

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.

Signature of Company Officer

Gerald L. Ganoni
Name

Vice President
Title

December 16, 2011
Date

HUMANA.
Guidance when you need it most

March 1, 2009

To: All State Insurance Departments

Humana Insurance Company hereby authorizes Insurance Compliance Consultants, Inc., to file the attached form(s) or a state specific variation of it, and to act on Our behalf regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. Humana Insurance Company may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,

Alan Stewart
Vice President
Humana Insurance Company

SERFF Tracking Number:	*ICCI-127881884*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*50504*
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Product Name:	*HIC Group Critical Illness - HIC GP CI 10/11*		
Project Name/Number:	*HIC Group Critical Illness /HIC GP CI 10/11*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/16/2011	Form	Employer Application	12/20/2011	HIC-CI-ERAPP 06-11 _rev 11-11_.pdf (Superceded)
12/16/2011	Form	Employee Enrollment form	12/20/2011	HIC-CI-EE-EF 6-11 _enrollment app_ 10-11-11 _2_.pdf (Superceded)
12/16/2011	Form	Evidence of Insurability form	12/20/2011	HIC-CI-EOI-APP 10-11 _Evidence of Insurability_ 10-11-11.pdf (Superceded)

POLICYHOLDER APPLICATION FOR
GROUP CRITICAL ILLNESS COVERAGE
Humana Insurance Company
1100 Employers Boulevard, Green Bay, Wisconsin 54344

ADMINISTERED BY:
Bay Bridge Administrators, LLC
P.O. Box 161690, Austin, TX 78716
800-845-7519

Name of Employer:		Tax ID #	Group #
Address:	City:	State:	Zip Code:
Email Address:	Phone Number:		Fax Number:
Contact Person:			
Nature of Business:		Effective Date of Coverage:	
Initial Enrollment: Start Date:		Stop Date:	
Waiting Period (if any) _____ Days			

Eligible Classes:
All active employees working a minimum of _____ regularly scheduled hours per week, per year.
(A minimum of [17.5] hours per week is required.)
[Other Named Class]
Are there any special eligibility or employee class requirements or restrictions? If so, please describe: _____

_____

_____

SIC Code_____

Number of eligible employees [ ]

Employee participation requirement for guaranteed issue [ ]

Minimum number of lives if not guaranteed issue [ ]

Plan Applied For:

[BASE PLAN WITH OPTIONS	
Vascular	**[Employee Benefit Amount**
Heart	_____
Heart Transplant	([$5,000] to [$100,000])
Stroke	
Coronary Artery Bypass Surgery (25%)	
Angioplasty (10%)	**Spouse Benefit Amount**
Cancer	_____
Invasive Cancer or Malignant Melanoma	([$5,000] to [$100,000])
Carcinoma in Situ (25%)	
Other Critical Illnesses	
Major Organ Transplant	
End Stage Renal Failure	**Child Benefit Amount**
Coma	_____
Severe Burns	([$5,000] to [$100,000])
Permanent Paralysis due to Accident	
Occupational HIV Benefit	
Loss of Vision, Speech, or Hearing (optional)	
Alzheimer's Dementia (25%)(optional)	
Loss of Independent Living (25%)(optional)	
Diabetes (Type 1 or II) (10%)(optional)	
Health Screening Benefit	_____ ($50 - $150)
Strike Waiver Rider]	

Is this a replacement of similar coverage: Yes No
Previous Company:

_____

Termination Date of Prior Plan:_____

Note: This Policy is not intended to replace comprehensive major medical insurance. The Acceptance letter will confirm your Policy selections.

Rates: Employee Only: _____ _____

Employee and Spouse: _____ _____

Employee and Children: _____ _____

Employee and Family: _____ _____

It is understood and agreed that this application shall be attached as a part of the Policy applied for, and that no insurance shall be effective until approved by Humana Insurance Company at it s home office.

I understand that Critical Illness covered persons are covered by group insurance benefits. The group insurance benefits vary depending on plan selected. These benefits are provided under a group insurance policy underwritten by Humana Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate which includes, but is not limited to, limitations for pre-existing conditions. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is a Critical Illness plan that provides for limitations to the coverage. The limitations are disclosed in the policy and certificate which are made available at the time of enrollment.

By the signature below of its duly authorized representative, the proposed Policyholder hereby applies for Humana Insurance Company Group Critical Illness Insurance; and the proposed Policyholder understands and agrees that the Policyholder and the Covered Persons shall be subject to the provisions set forth herein.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony.

Dated at:_____
(City, State)

By: _____
(Authorized Signature/Title)

On: _____
(Date)

For: _____

By: _____
(Printed Agent/Broker Name)

_____
(Signature of Agent/Broker)

ENROLLMENT FORM FOR GROUP CRITICAL ILLNESS COVERAGE
Humana Insurance Company
1100 Employers Boulevard, Green Bay, Wisconsin 54344

ADMINISTERED BY:
Bay Bridge Administrators, LLC
P.O. Box 161690, Austin, TX 78716
800-845-7519

NAME LAST	FIRST	MIDDLE	DATE OF BIRTH

STATE OF BIRTH	OCCUPATION	DATE OF HIRE	SOCIAL SECURITY NUMBER

MAILING ADDRESS	CITY	STATE	ZIP	HOME PHONE NUMBER

Complete for Family Coverage:

FIRST	LAST	DOB	AGE	SEX
SPOUSE				
CHILD				
CHILD				
CHILD				
CHILD				
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[POLICYHOLDER]	[GROUP POLICY NUMBER]	[DATE OF HIRE]	[AVERAGE WEEKLY HOURS]	[BUSINESS PHONE]

[Yes, I want the Critical Illness Coverage offered by the [Policyholder].] Total Deduction_____ (monthly, semi-monthly, weekly, bi-weekly, other_____)	[Select type of Coverage Eligible Person Eligible Person + Spouse Eligible Person + Child Eligible Person + Family

[Are you currently working a minimum of [17.5] hours per week? ☐ Yes ☐ No]

[Has any person to be insured used tobacco in any form in the last 12 months? ☐ Yes ☐ No If "yes," name(s) and usage:_____]

[No, I do not want coverage. I understand that if I want coverage at a later date, I will be required to provide evidence of insurability to Humana Insurance Company and my application for coverage may be declined by Humana Insurance Company.

_____ _____]
Signature, if declining coverage Date

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